



OR Blood Product Transfusion- Pediatric

The person initiating entry should write legibly, date the form (using Mo / Day / Yr), enter time, sign, and indicate their title.

Until signed, these are for general information and reference only. They should not be relied on as advice for a particular patient or situation or as a substitute for the independent professional judgment of the physician.

Date	Time	Physician Orders
<p>This Dynamic PowerPlan includes EKM rules to guide display of appropriate orders according to the legend: Age</p>		
<p>Height: _____ cm Actual Weight: _____ kg Weight for Calculation: _____ kg</p>		
<p>Blood Bank OR Blood Products Packed Red Blood Cell Modification Indications: CMV Negative- ALL solid organ transplant patients OR SCT patients with documented CMV Negative IgG Irradiated- ANY known or suspected immunocompromised patient or ANY patient less than 4 months of age, excluding solid organ transplants Washed- ANY patient with a repeated severe transfusion reaction, hyperkalemia or IgA deficiency Ultra-fresh- Consider for patients less than or equal to 17 kg that are receiving numerous or rapid transfusions Refer to PolicyStat ID: 3970810</p> <p>Platelet Modification Indications: CMV Negative- ALL solid organ transplant patients OR SCT patients with documented CMV Negative IgG Irradiated- ANY known or suspected immunocompromised patient or ANY patient less than 4 months of age, excluding solid organ transplants HLA Matched- Platelet refractory</p> <p style="background-color: yellow;"><i>If additional blood modifications are indicated, you must modify the order. To select multiple blood modifications, hold down CTRL and select modifications. Ex. Packed Red Blood Cells, CMV Negative, Irradiated.</i></p> <p> <input type="checkbox"/> Packed Red Blood Cells Leukoreduced CMV Safe <input type="checkbox"/> _____ Units <input type="checkbox"/> Platelets Leukoreduced CMV Safe <input type="checkbox"/> _____ Units <input type="checkbox"/> Fresh Frozen Plasma <input type="checkbox"/> _____ Units <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> _____ Units <input type="checkbox"/> RBCs –OR- Platelets Requested <input type="checkbox"/> CMV Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Washed (PRBCs ONLY) <input type="checkbox"/> Ultra-fresh (PRBCs ONLY) <input type="checkbox"/> HLA Matched (Platelets ONLY) <input type="checkbox"/> Other- Specify _____ <input checked="" type="checkbox"/> Priority <input type="checkbox"/> Routine </p>		

Practitioner Signature _____ Printed Name _____ Dictation# _____

Entered by: _____ Order Entry Verified _____

Sent to Pharmacy by: _____ (Scan, Tube / Fax / Copy) Date _____ Time _____



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Date	Time	Physician Orders
		This Dynamic PowerPlan includes EKM rules to guide display of appropriate orders according to the legend: Age
		<input type="checkbox"/> NOW <input type="checkbox"/> STAT Specify delivery date and time to coincide with procedure date and time <input checked="" type="checkbox"/> Clinical Indication <input type="checkbox"/> Needed in OR <input type="checkbox"/> Needed in Cath Lab <input type="checkbox"/> Needed in Interventional Radiology <input type="checkbox"/> Other- Specify _____
		Laboratory <input type="checkbox"/> Sickle Cell Antigen, Routine, STAT Select the below order if patient is greater than 4 months of age <input type="checkbox"/> ABO and RH, Routine, STAT <input type="checkbox"/> Indirect Antiglobulin Test, Routine, STAT Select the below order if patient is less than or equal to 4 months of age <input type="checkbox"/> Newborn Profile, Routine, STAT
		Medications Pre-Medications indicated for repeat or prior transfusion reactions <input type="checkbox"/> acetaminophen oral liquid 10-15 mg/kg= _____mg, Orally, Oral SOLN, Unscheduled, ONCE, May give PO/NG <i>Comments: Give 30 minutes before transfusion</i> **Maximum acetaminophen 75 mg/kg/day up to 4 grams per 24 hours from All Sources** <input type="checkbox"/> acetaminophen = _____mg, Orally, Tab, Oral Disintegrating, Unscheduled, ONCE <i>Comments: Comes in 160 mg OD Tab or 325 mg, 500mg, 650mg Tablet. Give 30 minutes before transfusion</i> **Maximum acetaminophen 75 mg/kg/day up to 4 grams per 24 hours from All Sources** <input type="checkbox"/> diphenhydrAMINE elixir 0.5 mg/kg= _____mg, Orally, Elixir, Unscheduled, ONCE, May give PO/NG <i>Comments: Give 30 minutes before transfusion</i> <input type="checkbox"/> diphenhydrAMINE 25-50 mg capsule= _____mg, Orally, Capsule, Unscheduled, ONCE <i>Comments: Give 30 minutes before transfusion</i> <input type="checkbox"/> diphenhydrAMINE 0.5mg/kg= _____mg, IV Push, Injection, Unscheduled, ONCE <i>Comments: Give 30 minutes before transfusion. Give injection over 5 minutes.</i>

Practitioner Signature _____ Printed Name _____ Dictation# _____

Entered by: _____ Order Entry Verified _____

Sent to Pharmacy by: _____ (Scan, Tube / Fax / Copy) Date _____ Time _____